Government of the District of Columbia
Department of Human Services
APPLICATION FOR BENEFITS

GENERAL INFORMATION

With this application, you can **APPLY** or be **RECERTIFIED** for one or more of the following assistance programs;

- **Medical Assistance**
- **Food Stamps**
- **Financial Assistance/TANF**

COMPLETING THIS APPLICATION

If you need help completing this application, a friend, relative or other individual may help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and the date next to the change. If more than 6 people are living in your home and you need more space to list everyone and complete information on any of the pages, tell the agency you need extra pages. If you want Medical Assistance and you are under 21 years of age, under certain circumstances your parent or legal guardian may need to sign the application.

If you are currently receiving benefits and are applying for **RECERTIFICATION** of Food Stamps or Financial Assistance/TANF this application form will be used for recertification of benefits. A different form will be provided if you are requesting recertification for Medical Assistance only.

This application contains information about the programs available at your local service center office plus other very important information you should know, including your rights and responsibilities. **READ THIS APPLICATION CAREFULLY AND THOROUGHLY.**

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may be denied. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be prosecuted for fraud.

VERIFICATION OF INFORMATION

The information that you give may be matched against Federal, State, and local records including the Department of Employment Services and the Department of Motor Vehicles, and the Income and Eligibility Verification System (IEVS) to determine if it is correct, accurate, and truthful. As a condition of eligibility you must apply for and cooperate with the agency in obtaining a social security number for yourself and the persons for whom you are applying for assistance.

In addition, your Social Security Number will be used to verify your identity, prevent receipt of duplicated benefits, and make required program changes. This system uses your Social Security Number to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration.

Any difference between the information you give and these records will be investigated and may require a home visit. Information from these records may affect your eligibility and benefit amount.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

1. When completing this application be sure to **PRINT ALL YOUR ANSWERS**.

2. Do not write in the shaded areas. **These areas are for agency use only**.

3. Answer the questions in **PART A: GENERAL INFORMATION** for everyone who lives in your home, even if you are not applying for that person.

4. Answer the questions in **PART B: RESOURCES** and **PART C: INCOME** for everyone for whom you are applying. In addition, if applying for **Medical Assistance** or **Financial Assistance/TANF**, also provide resource and income information for the following persons:

   - **Medical Assistance:** Spouse and children under age 21 who live with a person for whom you are applying, parents who live with a child under age 21, and the spouse of a person in a nursing facility, state hospital, or community-based care facility. Provide the spouse's shelter bills to your worker.

   - **Financial Assistance/TANF:** Children age 19 or under, even if you are not applying for that child.

5. After completing PARTS A, B, and C, answer the questions in the sections indicated below.

6. All applicants must carefully read and complete **PART G: YOUR RIGHTS AND RESPONSIBILITIES.** Be sure to complete and sign the "Assignment of Rights to Medical Support" on page 13 if you are applying for Financial Assistance or Medical Assistance. Be sure to provide the required signature(s) on the last page of this application.

7. Read **VOTER REGISTRATION** on page 14 of this application.

8. **BE SURE TO SIGN AND DATE PAGE 15 OF THIS APPLICATION.**

(Revised 7/29/98)

Government of the District of Columbia
Department of Human Services
APPLICATION FOR BENEFITS

AGENCY USE ONLY				
Case Name	**Case Number**	**Program**	**Worker Caseload**	**Date Received**
Service Center	**Date of Interview**		**Date of Disposition**	
Programs: Approved _____ **Denied** _____ **( ) Spend-Down**				

( ) Initial Application ( ) Recertification (Identify the program(s) from which you are applying for recertification in item number l.)

1. I WISH TO APPLY FOR: ( ) Medical Assistance ( ) Food Stamps ( ) Financial Assistance/TANF

Applicant's Name: (Last) (First)	**Social Security Number**:	**Phone Number:** **Home:** **Work:**
Other Names Used: Maiden: **Aliases**:		
Residence Address (Include City, State and Zip Code):		
Mailing Address (If Different):		

A. Does anyone have an emergency medical need**? YES ( ) NO ( )** If **YES**, give name and explain _____
_____

B. Is the applicant living in a Community Residential Facility, a State Hospital, a Nursing Home, or other institution? **YES ( ) NO ( )**
If **YES**, provide date entered: _____ If outside the **District of Columbia**, was placement made by a government agency? **YES ( ) NO ( )**

C. Is the applicant: SINGLE ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) WIDOWED ( ) If **SEPARATED** provide: Date of separation: _____
Spouse's Name _____ Spouse's Address _____

YES ( ) NO ( ) 2. Have you or anyone for whom you are applying ever applied for or received any benefits from the District of Columbia or another State, including TANF, Food Stamps, or any other assistance? If **YES**, provide the information in the box below.

Applicant's Name:	**Social Security Number:**	**Dates Received Assistance:**
Type of Benefits Applied For or Received:		
From What Country, City or State:		

YES ( ) NO ( ) 3. If you are not registered to vote where you currently live, would you like to register to vote here today?

YES ( ) NO ( ) 4. Are you or anyone for whom you are applying either a convicted felon in flight to avoid capture or in violation of probation or parole?

YES ( ) NO ( ) 5. Do you and those for whom you are applying plan to remain in DC? If no, Please explain: _____

PART A: GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

1. In the boxes provided below, list everyone living in your home, even if you are not applying for assistance for that person.
(Race information is not required.)

Check (√) **YES ( ) NO ( )** Do you expect any change in who lives in your home, either this month or next month? If YES, explain:

Identify the type(s) of Program Assistance being requested for each person by placing the appropriate Program Code(s) in the box provided below labeled "Program". Program Codes: **M...**Medical Assistance **FS...**Food Stamps **T...**TANF/Financial Assistance **N...**None

2. Relationship to Person Applying on Line #1-Self

Identify the relationship of each person to the person listed on Line #1.

Program	**NAME (Self):**					**Client ID #:**	**SELF**
	Date of Birth:	Place of Birth:	Age:	Sex:	Race:	Social Security #:	
Program	**NAME:**					**Client** ID #:	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race:	Social Security #:	
Program	**NAME**:					**Client ID#:**	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race:	Social Security #:	
Program	**NAME:**					**Client ID #:**	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race:	Social Security #:	
Program	**NAME:**					**Client ID #:**	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race:	Social Security #:	
Program	**NAME**:					**Client ID #:**	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race:	Social Security #:	
Program	**NAME:**					**Client ID #:**	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race:	Social Security #:	

YES ( ) NO ( ) 3. Is anyone for whom you are applying temporarily away from the home ? If **YES**, provide: Person(s) Name:_____
_____ Expected Date of Return:_____

YES ( ) NO ( ) 4. Are you or anyone for whom you are applying pregnant? If **YES**, provide: Person(s) Name:_____
_____ Expected Delivery Date:_____

Government of the District of Columbia
DEPARTMENT OF HUMAN SERVICES
INCOME MAINTENANCE ADMINISTRATION

CITIZEN/ALIENAGE DECLARATION

I certify under penalty of perjury, by signing my name below, that I am an adult U.S. citizen, U.S. national, or qualified alien. Also, I certify that the information on this form is true and that each member of the household who is applying for benefits listed below is a citizen or qualified alien.

Please note that only information regarding household members applying for benefits is required on this form.

Name	Citizen or Alien	Date of Birth	SSN#	Disabled (Y/N)	Alien #	Verification #

Signature of Adult_____

Worker _____ Cert.Location _____

Telephone: _____ Case Number _____

DHS – 1926 rev 2/99

PART B: RESOURCES (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the questions below for everyone for whom you are applying. If applying for **Medical Assistance or Financial Assistance/TANF, also provide** resource information for the additional persons indicated on page 2 of this application. Include any resources anyone owns, is currently buying or has inherited. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the amount of the resource owned by that person. **Refer to #4 on the instruction page and talk to your worker if you need help answering these** questions.

YES ( ) NO ( ) 1. Cash on hand and not in a bank? If **YES**, list owner(s) _____ Amount_____

YES ( ) NO ( ) 2. Checking account, savings account, credit union account, Certificate of Deposit or money market account, patient funds for people in a nursing facility or Community Residence Facility (CRF)? List all accounts, even if there is no money in the account.

Owner	**Type of Account** **Account #**	**Where**	**$ Amount**	**Date Acquired**
Owner	**Type of Account** **Account #**	**Where**	**$ Amount**	**Date Acquired**

YES ( ) NO ( ) 3. Tax refunds, stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, or deeds of trust?

Owner	**Type**	**Where**	**$ Amount**	**Date Acquired**
Owner	**Type**	**Where**	**$ Amount**	**Date Acquired**

YES ( ) NO ( ) 4. Health Insurance?

Policy Holder	**Company Name, Address, Phone**	**Begin Date** **End Date**	**ID Number** **Premium $**	**Type of Coverage**	**Person(s) Insured**

YES ( ) NO ( ) 5. Medicare?

Person Insured	**Claim Number**	**Check (√)** **( ) Part A ( ) Part B**	**Begin Date** **End Date**	**Premium** **$**	**Payment Method**

YES ( ) NO ( ) 6. Life Insurance policies? **(NOT REQUIRED FOR FOOD STAMP APPLICANTS WHO ARE NOT ELDERLY OR DISABLED)**

Owner(s)	**Person(s) Insured**	**Company Name, Address, Phone**	**Policy #**	**Cash Value**

YES ( ) NO ( ) 7. Licensed or unlicensed vehicles, such as cars, trucks, vans, boats, recreational vehicles, or motorcycles/mopeds?

Owner(s)	**Year-make-model**	**License #**	**$ Value** **$ Amount Owed**	**How is vehicle used?**	**Date Acquired**
Owner(s)	**Year-make-model**	**License #**	**$ Value** **$ Amount Owed**	**How is vehicle used?**	**Date Acquired**

YES ( ) NO ( ) 8. Personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, or supplies?

Owner	Type	**YES ( ) NO ( ) Is this property necessary to your own business?**	**$ Value** **$ Amount Owed**	**Date Acquired**
Owner	**Type**	**YES ( ) NO ( ) Is this property necessary to your own business?**	**$ Value** **$ Amount Owed**	**Date Acquired**

YES ( ) NO ( ) 9. Real property, inc1uding life estates, land, buildings, or mobile homes? If **YES**, did you live there? Check (√) **YES ( ) NO ( )**

Owner	**Type**	**YES ( ) NO ( ) Income producing** **YES ( ) NO ( ) Currently for sale**	**$ Value** **$ Amount Owed**	**Date Acquired**
Owner	**Type**	**YES ( ) NO ( ) Income producing** **YES ( ) NO ( ) Currently for sale**	**$ Value** **$ Amount Owed**	**Date Acquired**

YES ( ) NO ( ) 10. Burial plots, burial arrangement or trust funds for burial?

Owner	**Number of Plots, Type of Arrangement**	**Where**	**$ Value** **$ Amount Owed**	**Date Acquired**
Owner	**Number of Plots, Type of Arrangement**	**Where**	**$ Value** **$ Amount Owed**	**Date Acquired**

YES ( ) NO ( ) 11. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for **Food Stamps**? In the last 2 years, if applying for **Cash Assistance/TANF** or **Medical Assistance**?

Property Transferred		**Value at Transfer**	**Amount Received**	**Explain Reason for Transfer**
From Whom	**To Whom**	**Date Acquired**	**Date Transferred**	

YES ( ) NO ( ) 12. Does anyone expect to receive any money because of a legal suit involving a personal injury or property damage? If YES, explain.

_____

_____

_____

YES ( ) NO ( ) 13. Does anyone expect a change in resources this month or next month? If **YES**, explain and give date change is expected.

_____

_____

_____

_____

PART C: INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the income questions for everyone for whom you are applying. Income means any money you received from working or money you received from any other source. If applying for Cash Assistance or **Medical Assistance**, also provide income information for the additional persons indicated on page 2 of this application. For **Financial Assistance** or **Medical Assistance** for children, also provide income information for the child's parent or stepparent living in the home. If the parent is a minor under age 18 (for **Financial Assistance**) or under age 21 (for **Medical Assistance, if applicable**), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (√) **YES** or **NO** for each type. If **YES**, give the information requested.

1. YES( ) NO ( ) Wages/salary
2. YES ( ) NO ( ) Babysitting/Child care
3. YES ( ) NO ( ) Seasonal Work
4. YES ( ) NO ( ) Domestic Work
5. YES ( ) NO ( ) Odd Jobs
6. YES ( ) NO ( ) Other self-employment
7. YES ( ) NO ( ) Other income from working?
If YES, specify:_____

Item #	Person Receiving Money from Working	Employer's Name, Address, Phone Number	Employment Begin Date	Hours Worked Per Month	Rate of Pay Per Hour	How Often Paid	Gross Monthly Pay Before Deductions

2. Does anyone receive any other type of money? Check (√) **YES** or **NO** for each type. If **YES**, give the information requested.

1. YES ( ) NO ( ) Social Security
2. YES ( ) NO ( ) SSI
3. YES ( ) NO ( ) VA benefits
4. YES ( ) NO ( ) Retirement benefits
S. YES ( ) NO ( ) Public assistance
6. YES ( ) NO ( ) Child support/alimony
7. YES ( ) NO ( ) Unemployment benefits
8. YES ( ) NO ( ) Worker compensation
9. YES ( ) NO ( ) Tax Refunds
10. YES ( ) NO ( ) Prize winnings
13. YES ( ) NO ( ) Cash gifts/Contributions
14. YES ( ) NO ( ) Military allotment
15: YES ( ) NO ( ) Room/board income
16. YES ( ) NO ( ) Rental income
17. YES ( ) NO ( ) Insurance settlement
19. YES( ) NO ( ) Training allowances
20. YES ( ) NO ( ) Loans
21. YES ( ) NO ( ) Other type of money?
If YES, specify:_____

Item #	Person Receiving Money	Type of Money Received	How Often Received	When Received	Gross Monthly Amount Before Deductions
					$
					$
					$

YES ( ) NO ( ) 3. Is anyone a veteran of the armed services? If **YES**, provide: Name:_____
Date Served:_____ Serial #:_____

YES ( ) NO ( ) 4. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

Name of Person	Employer's Name, Address, Phone	Employed From/To	Hrs./Wk. Worked	Rate of Pay	How Often Paid	Date Last Pay Received	Reason for Leaving, Reducing Hours
				$			

YES ( ) NO ( ) 5. Does anyone besides the people for whom you are applying pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills, or any other bills?

Person Receiving Help	Person Providing Help	Type of Help Received	Amount	Does Money Come Directly to You?	Is This a Loan?	Is Repayment Expected?
			$	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )

YES ( ) NO ( ) 6. Has anyone applied for or received student financial aid or work-study for a current school term at a college or university? Or, any school or training program beyond the high school level? Or, any school or training program for the physically or mentally disabled?

Name of Person	Type of Financial Aid	Amount	Period Covered	Tuition Fees	Books Supplies	Dependent Care	Room and Board	Other (Specify)
		$	From: To:	$	$	$	$	Item: $
		$	From: To:	$	$	$	$	Item: $

YES ( ) NO ( ) 7. Does anyone pay for dependent care expense for a child, an elderly person, or an adult with a disability?

Person Paying for Care	Person Receiving Care	Check (√) If Disabled	Provider's Name, Address, Phone Number	Amount Paid

YES ( ) NO ( ) 8. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month? If **YES**, explain and give date:_____

YES ( ) NO ( ) 9. Does anyone pay legally obligated child support to someone not in the household? If **YES**, Person paying:_____
Person supported:_____ Amount paid, how often: $_____

YES ( ) NO ( ) 1. Does anyone who is included in this application have any **unpaid** medical bills for medical services that were received during the three months before the month of application? If **YES**, complete the boxes below.

Patient's Name	Kind of Medical Expense	Date of Service	Amount Owed	Amount Still Owed

YES ( ) NO ( ) 2. Have you or anyone for whom you are applying been hospitalized as the result of an accident in the last three months? If **YES**, complete the boxes below.

What Happened, Where, How	Name, Address of Person at Fault	Is a Liability Suit Planned or in Progress? YES ( ) NO ( )
Name, Address of All Insurance Companies Involved	**Name, Address, Phone Number of Your Attorney**	

YES ( ) NO ( ) 3. Are you requesting Medical Assistance for the last three months prior to this application? If **YES**, answer the following questions.

YES ( ) NO ( ) a. Did your address change at any time during the last three months? If **YES**, describe the changes:_____
_____

YES ( ) NO ( ) b. Was there any change in who was living with you during this period? If **YES**, describe changes:_____
_____

YES ( ) NO ( ) c. Was there any change in anyone's income or assets during this period? If **YES**, describe changes:_____
_____

YES ( ) NO ( ) 4. **Answer Only If Someone Is Applying for Medical Assistance and Is Blind or Disabled:** Does this person have a work related expense? If **YES**, give amount and explain. _____

YES ( ) NO ( ) 5. Have you been informed about the Early Periodic Screening, Diagnosis and Treatment (ESPDT) or the Medicaid Well Child program?

YES ( ) NO ( ) 6. Would you like a referral to be made to the ESPDT or Medicaid Well Child program?

YES ( ) NO ( ) 7. I understand that in the event of my death, the Department may make a claim against my estate for the amount of Medical Assistance paid on my behalf after my 65th birthday. The Department will not make a claim if I die leaving a surviving husband or wife or child who is under age 21 or who is blind or permanently and totally disabled.

		Answer Questions **3 & 4 Only** if the answer to Question 2 is **"Absent"**	
1. **List each child for whom you are applying. Then, list the names of both parents.** You **must** identify both parents in order to receive Cash Assistance.	2. Provide the appropriate CODE in the box below if either PARENT is: **U…..**Unemployed **DI….**Disabled **DE…**Deceased **A…..**Absent	3. **Reason for Absence:** Provide the appropriate CODE in the box below for each absent parent. **S…**Separated **P…**No Paternity Established **D…**Divorced **I….**Incarcerated **D…**Deserted	4. **Financial Support:** Does the **absent parent** regularly provide monthly financial support? Check (√) **YES** or **NO** in the boxes provided below. If **YES**, give amount, and how often received.
Child's Name			
Mother			**YES ( ) NO ( ) $**
Father			**YES ( ) NO ( ) $**
Child's Name			
Mother			**YES ( ) NO ( ) $**
Father			**YES ( ) NO ( ) $**
Child's Name			
Mother			**YES ( ) NO ( ) $**
Father			**YES ( ) NO ( ) $**
Child's Name			
Mother			**YES ( ) NO ( ) $**
Father			**YES ( ) NO ( ) $**
Child's Name			
Mother			**YES ( ) NO ( ) $**
Father			**YES ( ) NO ( ) $**

1. Provide the name of the person who is the head of your household in the box

HEAD OF HOUSEHOLD

YES ( ) NO ( ) 2. Would you like to name one or more authorized representatives who could apply for food stamps for you, pick up or receive food stamps for you, use your food stamps in grocery stores for you, or receive food stamp correspondence and notices for you?

NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)		**CHECK (√) EACH DUTY AUTHORIZED FOR THAT PERSON**
1		**( ) Apply for food stamps** **( ) Use food stamps** **( ) Receive food stamps** **( ) Receive correspondence**
2		**( ) Apply for food stamps** **( ) Use food stamps** **( ) Receive food stamps** **( ) Receive correspondence**

An authorized representative must have written permission to apply for food stamps. This permission can be given in the space above or in a letter. Permission can only be given by the head of the household.

YES ( ) NO ( ) 3. Is anyone living in your home NOT included on your Food Stamp application? If YES, answer Question **"a"**.

a. **YES ( ) NO ( )** Do you and everyone for whom you are applying intend to purchase and prepare meals apart from these people?

YES ( ) NO ( ) 4. Is anyone age 60 or older, **OR** disabled? If disabled, identify the disability:_____

If **YES**, list below all the current medical expenses for these people, including Medicare premiums, other medical insurance premiums, medical and dental bills, prescription drugs, eyeglasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. ALSO, indicate how you would like these medical expenses deducted in order to determine your food stamp benefits. TALK TO YOUR WORKER BEFORE SELECTING A METHOD OF DEDUCTION.

PERSON WITH EXPENSE	**TYPE OF EXPENSE**	**AMOUNT**	**NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY**	**METHOD OF DEDUCTION**
		$		**( ) Lump Sum ( ) Monthly Average ( ) Expected Payment**
		$		**( ) Lump Sum ( ) Monthly Average ( ) Expected Payment**
		$		**( ) Lump Sum ( ) Monthly Average ( ) Expected Payment**

FOOD STAMP EXPENSES

If you report and provide proof of your expenses shown in the Food Stamp Section, you will get the maximum amount of food stamps allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense. (Authority: United States Department of Agriculture Administrative Notice 6-99, issued January 4, 1999)

_____ _____

Applicant's or Authorized Representative's Signature or Authorized Mark Date

_____ _____

Witness Signature to Mark or Interpreter Date

YES ( ) NO ( ) 5. Does anyone have any shelter expense for rent or mortgage, real estate tax, property tax, homeowner's insurance, electricity, gas, oil, water or sewer, or telephone? If **YES**, answer Questions **"a"** and **"b"**. Then, give the information requested in the boxes.

a. **YES ( ) NO ( )** Are any utilities included in your rent? If **YES**, leave the boxes for those expenses blank.

b. **YES ( ) NO ( )** Are taxes or insurance included in your mortgage payment? If **YES**, leave those boxes blank.

Expense	Rent or Mortgage	Taxes	Insurance	Telephone	Electricity	Gas	Oil	Water/sewer
Amount Billed	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**
How Often								
Who Pays Bill								

YES ( ) NO( ) 6. Does anyone have or expect to have an expense for heating or cooling the home? Or, has anyone received assistance from the Fuel Assistance Program during this past year?

If **YES**, check (√) whether you would like your food stamp benefits determined using your actual utility expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. **Actual Utility Expenses** ( ) **Utility Standard** ( )

If the **Utility Standard** is selected, does anyone living in your home but not included on your Food Stamp application help you pay your heating or cooling bill? Check (√) **YES ( ) NO ( )** If **YES**, explain:_____

YES ( ) NO ( ) 7. Are you **temporarily** staying in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If **YES**, provide the date you moved in:_____

YES ( ) NO ( ) 8. Does anyone have a shelter expense for a home (rented or owned) that is temporarily not lived in because of employment or training away from the home, illness, or a disaster?

Reason for Not Living There	Does Person Intend to Return?	Type and Amount of Shelter Expenses	Is Someone Else Living There?	If Someone Else Lives There, Does That Person Pay Rent?
	YES( ) NO( )		**YES( ) NO( )**	**YES ( ) NO( )**

CHANGES

You must report all required changes within the time limits required. The following examples do not include every change which you must report. If you are not sure whether to report a particular change, discuss this with your worker.

- **Food Stamps**

(REPORT CHANGES WITHIN 10 DAYS)

1) Change of address and any changes in shelter costs due to the move
2) Change in the persons in the household
3) Change in source of income, including getting a new job
4) Change in monthly income of more than $80
5) Change in resources
6) Change in motor vehicles owned
7) Change in legally obligated child support payments

- **Financial and Medical Assistance**

(REPORT CHANGES WITHIN 10 DAYS)

1) Change of address
2) Change in marital status
3) Change in the persons in the household
4) Child turns 18
5) Person in home is no longer disabled
6) Change in income
7) Change in resource
8) Change in motor vehicles owned
9) Change in dependent care expenses

PENALTIES FOR TANF VIOLATIONS

You must not knowingly give false information; hide information, or fail to report changes on time in order to receive TANF. If you are found guilty after an agency hearing or by the courts of intentionally breaking these rules, your needs will be removed from the grant for the following periods: 6 months (1st offense), 12 months (2nd offense), or permanently (3rd offense). Anyone convicted of misrepresenting their residence to get TANF in two or more states is ineligible for TANF for 10 years.

PENALTIES FOR FOOD STAMP VIOLATIONS

You must not give false information or hide information to get food stamps. You must not trade or sell food stamps or ATP/EBT cards. You must not change ATP/EBT cards to get food stamps you are not eligible to receive. You must not use food stamps to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's food stamps or ATP/EBT card for your household.

Anyone who intentionally breaks any of these rules could be barred from the Food Stamp Program for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); is subject to a $250,000 fine, may be imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

Anyone who intentionally gives false information or hides information about identity or residence to get Food Stamps in more than one locality at the same time could be barred for 10 years. Anyone convicted of trading or selling Food Stamps of $500.00 or more could be barred permanently. Anyone convicted of a drug related felony committed after August 22, 1996 could be barred permanently from receiving Foods Stamps.

INFORMATION ABOUT THE OFFICE OF PATERNITY AND CHILD SUPPORT ENFORCEMENT (OPCSE)

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. You must give to OPCSE any support payments you receive after you receive your first TANF check. By accepting the TANF check, you are agreeing to assign these rights and to cooperate with the agency efforts.

"GOOD CAUSE" WORK EXEMPTIONS

You must participate in a job search or another work activity as a condition of eligibility for benefits. You will not be required to participate if one or more of the following pertains to you:

- You have a child under age 1;
- You are age 60 or older;
- You are responsible for the care of a disabled child or adult relative in the home
- You or other household member(s) are ill which requires you to stay home;
- There is no adequate or affordable child care for your children under age six; or
- There is a family emergency such as a death in the family or other crisis, which is beyond your control and which prevents your participation in a work activity.

MEDICAID WELL-CHILD PROGRAM

The Well-Child Program provides free checkups and treatment to Medicaid eligible children under age 21. The Well-Child Program is very important and can be obtained from any doctor or clinic participating in the Medicaid program. The Well-Child Program also helps in scheduling appointments and providing transportation to the doctor's office. For help in scheduling appointments and providing transportation call 1-800-MOM-BABY. For more information about the program, call (202) 727-0725.

RIGHT TO MEDICAL SERVICES

If during a period when you are eligible for Medicaid, the ELIGIBILITY VERIFICATION SYSTEM (EVS) informs you or your provider that you are not eligible for Medicaid and you dispute that determination, you may obtain free legal assistance by contacting Terris, Pravlik & Millian at 1121 12th Street, N.W. Washington, D.C., (202) 682-0578. Your provider has been instructed to call the EVS backup system.

MEDICAID RECERTIFICATION PROCESSING

You are responsible for submitting all of the documents and providing all of the information requested in connection with the recertification of your Medicaid eligibility. If you return all of the documents requested before the end of your current Medicaid eligibility period, the Department of Human Services MUST either approve or disapprove your request or continue your eligibility until a determination of ineligibility is made and you are given written notice of that decision. If you are determined no longer to be eligible for Medicaid, you have a right to request a hearing to challenge that determination. If you have not received written notice that your recertification has either been approved or denied by the end of your current eligibility period, and your eligibility has not been continued, you can obtain free legal assistance by calling the firm of Terris, Pravlik & Millian at 1121 12th Street, N.W. Washington, D.C., (202) 682-0578.

RIGHT TO A FAIR HEARING

If you are not satisfied with the Department's action on your application and the reason for this action, you may request a fair hearing within 90 days. You have the right to obtain legal counsel on your behalf. If you make a timely request for a hearing your benefits will continue until a hearing decision is rendered. If you do not make a timely request for a hearing, your benefits will not continue; however, you may within 90 days from the date of a notice request a hearing. Your worker will gladly answer questions concerning your application and the fair hearing process.

If you believe you have been discriminated against because of race, color, sex, national origin, or handicap you may file a complaint with the D.C. Department of Human Services or the Federal Department of Health and Human Services within 180 days from the date of receiving a notice from the Department on their decision regarding your eligibility for benefits. If you are not eligible for financial/medical assistance at this time, you may reapply if your situation changes.

ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT

In order to receive Medical Assistance/Medicaid, each person age 18 or older is required to assign all rights to medical support to the Department of Human Services. This means that you must give to the Department any payment for medical services you receive from another insurer. You are also required to assign these same rights for everyone for whom you have the legal rights to do so. Failure to assign your rights to medical support will make you ineligible for Medical Assistance/ Medicaid. Failure to assign the rights of anyone else will not make that person ineligible.

DIRECTIONS: Use column A, initial one of the statements, and sign your name. Any other person age 18 or older should use column B, initial one of the statements, and sign his/her name.

A	B	
__	__	**I agree to assign my rights and the rights for everyone for whom I have the legal right to do so.**
__	__	**I refuse to assign my rights.**
__	__	**I refuse to assign the rights of: (give name)**_____

Signature A:_____

Signature B:_____

VOTER REGISTRATION

On **Page 1** of this application, you were asked whether you would like to register to vote here today. **Your worker will check the statement below which applies to you.**

- ☐ **You indicated that you would like to apply to register to vote and a voter registration application form was given to you to complete. If you would like help in filling out the voter registration form, we will help you. The decision to accept help is yours. You also have the right to complete your voter registration application form in private.**

- ☐ **You are already registered to vote at your current address, you are not eligible to register to vote, or you otherwise do not want to apply to register to vote today.**

- ☐ **You did not respond when asked if you wanted to apply to register to vote. <u>Your failure to respond indicates that you will be considered to have decided not to register to vote at this time.</u>**

Applying to register or declining to register to vote will not affect the assistance or services provided to you by this agency. A decision not to apply to register to vote will remain confidential. A decision not to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: The District of Columbia Board of Elections and Ethics, 441 4th Street, N.W., Suite 250, Washington, D.C. 20001 - Phone: 202/727-2525.

ACKNOWLEDGMENT OF TANF PROGRAM REQUIREMENTS

I acknowledge that the requirements of the Temporary Assistance to Needy Families (TANF) program have been explained to me. I understand that TANF is not an entitlement program and I have been informed of the limitations and penalties of the TANF program. Specifically, I have been made aware of the following provisions:

- 60 month lifetime limit
- Teen parent home-living requirement
- Teen parent school attendance requirement
- Parent may be required to look for work immediately and sign individual plans that describe the steps he/she must take to become self-sufficient
- Assignment of support rights
- Cooperation with the child support agency
- 10 year ban for misrepresenting residence to obtain benefits in two or more states
- Denial of assistance for fugitive felons and probation/parole violators
- Denial of assistance for minor children absent from home in excess of 90 days

MY SIGNATURE ON PAGE 15 CERTIFIES THAT I HAVE READ AND UNDERSTAND THE TANF PROGRAM REQUIREMENTS.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) – CUSTOMER/AGENCY AGREEMENT

I, _____, acknowledge that I must participate in job search or job readiness activities, as a condition of eligibility for TANF benefits. I understand that if I do not participate in these activities, my needs will not be reflected in my family's grant. If I am receiving assistance and I fail to comply with this agreement, I understand that my needs will not be reflected in my family's grant. Furthermore, I agree to take an active role in the development of my plan for self-sufficiency with District of Columbia Government staff, including the determination of long and short-range goals that will enhance my ability to achieve self-sufficiency. I will advise the appropriate staff of the Income Maintenance Administration (IMA) and the Department of Employment Services (DOES) of any conflicts and emergencies which may require a change in my participation. I understand that I may be asked by the District of Columbia to sign an Individual Responsibility Plan and that my level of assistance will be based on compliance with that plan, once I have been determined eligible for TANF.

MY SIGNUTURE BELOW CERTIFIES THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT.

BY MY SIGNATURE BELOW, I DECLARE UNDER PENALTY OF PERJURY THAT ALL OF THE FOLLOWING IS TRUE:

I UNDERSTAND:

- All of the information provided in this application.
- If I give false, incorrect, or incomplete information, including intentionally misidentifying the parent of a child, or do not report required changes on time, I may be breaking the law and could be prosecuted for perjury, larceny, or welfare fraud.
- If I helped someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.
- If I refuse to cooperate with any review of my eligibility or recertification, including reviews by Quality Control, my benefits may be denied until I cooperate.

Everyone for whom I am applying is either a U.S. citizen or an alien in lawful immigration status, unless I am only applying for emergency medical services for which there is not a citizenship or lawful alien requirement. All information on this application is correct and complete to the best of my knowledge and belief, including information about citizenship and alien status.

MY SIGNATURE BELOW, AUTHORIZES THE RELEASE OF ALL INFORMATION, which will be considered confidential, to a representative of the Department of Human Services (DHS). All persons, firms, corporations, commissions, agencies and organizations of any kind, whether public or private, having knowledge of my financial, medical or other circumstances, are hereby authorized to answer in full any questions which may be asked by DHS of the applicant or recipient.

I filled in this application myself. **YES ( ) NO ( )** If NO, it was read back to me when completed. **YES ( ) NO ( )**

Applicant's or Authorized Representative's Signature or Mark:	**Date:**	**Spouse or Authorized Representative's Signature or Mark:**	**Date:**
Witness Signature to Mark or Interpreter:	**Date:**	**Worker's Signature:**	**Date:**

Complete the box below if this application was completed by someone other than the application.

Person Completing Application:	**Date:**	**Address:**
Phone Number(s): (Home) (Work)		**Relationship to Applicant:**